TESTIMONY OF CLAUDIA J. BEVERLY, PHD, RN, FAAN TO THE POLICY COMMITTEE OF THE WHITE HOUSE CONFERENCE ON AGING SOLUTIONS FORUM ON ELDER CAREGIVING

Brief Bio

Claudia Beverly, RN, received her Ph.D. in nursing from the University of Tennessee, Memphis, Tennessee with a focus in Health Services Research in Community Based Care for Older Adults. Currently, she serves as Professor, Colleges of Nursing, Medicine and Public Health; the Associate Director, Donald W. Reynolds Center on Aging, Vice Chair for Programs, Department of Geriatrics; College of Medicine, and Director of the Arkansas Aging Initiative, Donald W. Reynolds Institute on Aging. Dr. Beverly is also the Director of the Hartford Center for Geriatric Nursing Excellence, College of Nursing, University of Arkansas for Medical Sciences. She is the past President of the AR Nurses Association and is also the past President of Gamma XI Chapter, Sigma Theta Tau International. She is a Fellow in the American Academy of Nursing

A published author, national presenter, instructor for UAMS and a registered nurse, she is a member of the American Nurses Association, Gerontological Society of America as well as other professional organizations. She is the recipient of various awards including selection in the first cohort, Robert Wood Johnson Nurse Executive Fellowship and received the Distinguished Alumnus of UAMS Award in 1992. Her most recent appointment is to the National Advisory Council on Nurse Education and Practice of the Health Resources and Services Administration by Donna Shalala, former Secretary of Health and Human Services. In the 1993 legislative session, Dr. Beverly fulfilled a Health Care Policy Internship with the Arkansas Senate Public Health, Welfare, and Labor Committee and lead efforts in 1995 to successfully seek APN licensure and prescriptive authority in Arkansas. Dr. Beverly's current area of expertise is developing integrated models of health care and social services delivery and workforce issues across the continuum of geriatric settings.

SUMMARY OF FINDINGS

The Donald W. Reynolds Institute on Aging (RIOA) is addressing one of the most pressing policy issues facing this country: how to care for the burgeoning number of older adults. In 2001, the RIOA created the Arkansas Aging Initiative (AAI), which established seven satellite centers on aging across the state with $1.5 to 2 million dollars annually from the state's portion of the master tobacco settlement. These centers are using a prevention framework to assist aging Arkansans by making geriatric specialty and primary care more accessible and by providing multiple avenues of education for the community, healthcare providers, family, and caregivers. The long-range goal is to improve health and quality of life of older Arkansans thus enabling them to remain independent and in their own home.

The problems of In-Home Care and how to care for an aging population is multi-factorial and includes the following:

Lacks of appropriate models of care delivery

- Few models of care delivery focus on keeping older adults healthy, independent and at home. Furthermore, this type care receives minimum reimbursement, if any.
- Few models focus on developing programs targeting informal caregivers. The majority does not assist the informal caregiver to stay healthy by focusing on their own health nor do they assist them to develop an infrastructure that most appropriately supports their care giving needs. Without this assistance, their caregiving efforts are difficult causing their health to deteriorate and their cargiving time to decrease.
- The current health care delivery and social service network are often fragmented and found working in parallel and lack true integration. The closest model to achieve integration is the PACE model but even then, true interdisciplinary management is often lacking. Additionally, this model only addresses the frail elderly and does not focus on keeping older adults healthy.
- In response to the Consumerism movement in the 1990's, many healthcare providers have come to expect the healthcare consumer to actively participate in their healthcare decisions as well as maintenance and prevention activities that promote a healthy life style. As well as main their healthcare and their healthcare decisions –this is a tremendous challenge for many older adults. Even though the young baby-boomers embrace or are the driving force behind consumer-driven care; for the 85+, it is not a natural process and they frequently give up their right and leave the healthcare professional to make the decisions for them.

Demographic trends

- The overall 65+ population is growing and is expected to reach 20% of this country's total population by 2030. By 2031, there will be almost twice as many older Americans as today—from 37 million today to 71 million.
- The 85+ population in this country is growing exponentially
  - 34% increase nationally from 1993-2003
  - 27% increase in Arkansas from 1993-2003
  - This represents an increase in Arkansas from approximately 39,000 to 50,000 in just a ten-year period. This trend is expected to continue.

- Arkansas ranked 9th in the nation in the year 2003, with 359,150 persons age 65 and older which represented 13.6% of the total state population.
- The poverty rate of rural Arkansans is 17.8%, which is substantially higher than that of urban Arkansans (13.8%) and Americans in general (12.4%).
- Almost 60% of Arkansans live in medically underserved areas.
- Nearly 25% of Arkansans live in health professional shortage areas.
- By 2025, the proportion of older Arkansans is projected to increase to 23.9%, and the state is expected to have the 5th highest proportion of elders in the nation.
- Shrinking informal and formal caregivers. There are currently 3.3 workers for each Social Security beneficiary. By 2031, there will be 2.1 workers for each beneficiary.
- Women are usually the primary caregivers and over 70% are now in the workforce.

Increasing incidence of Dementia, particularly Alzheimers

- The incidence of dementia in 65+ is approximately 10-12% and increases to 49-50% in the 85+ population
- Individuals who are cognitively impaired bring unique caregiving challenges that vary greatly from those who are physically impaired

Access is limited due to several factors

- Reimbursement for services is usually inadequate and varies from state to state. Arkansans, in a recent needs assessment, rated cost as the number one problem in their over all health care needs.
- Rural states such as Arkansas lack public transportation even in the more urban settings. Adding to lack of transportation is the geographic distance older adults must travel and compounding this is that as older adults age, they quit driving and become dependent on family and friends.
- Healthcare providers have come to expect healthcare consumers to actively participate in their healthcare decisions as well as maintenance and prevention activities that promote a healthy life style–this can be a tremendous challenge for many older adults.
- Young baby-boomers are the driving force behind consumer-directed care but for the 80+, it is a foreign process and they frequently give up this right and leave the healthcare professional and frequently un-informed family members to make healthcare decisions for them.
- Many older Arkansan and their families live in poverty and have low literacy levels. Multiple studies have shown that poor health outcomes are positively associated with low literacy levels thus increasing the cost of care.

- Workforce
    - Too few numbers of providers choosing to go into geriatrics especially noted in nursing and medicine
    - Too few examples of private/public funding for geriatric education such as that already made by the John A. Hartford Foundation and the Donald W. Reynolds Foundation
    - Recruitment of individuals into certified nursing assistant or personal care positions is difficult and has resulted in a dearth of individuals to be employed at this level.

RECOMMENDATIONS AND REFORMS

The five major areas were identified for policy recommendation and reforms: 1) access; 2) workforce; 3) consumer directed care; 4) reimbursement/cost; and 5) prevention

1) Increase access to quality specialized interdisciplinary geriatric healthcare

- CMS and AHRQ should fund demonstration projects to examine the efficacy of the interdisciplinary geriatric primary care team in rural settings. There is compelling evidence to support the efficacy of interdisciplinary geriatric primary care. Multiple studies support the satisfaction and positive health outcomes of this approach. All of these studies were in urban or VA settings.
- Medicare should reimburse for interdisciplinary interactions and patient care planning.
- There is evidence that older adults and their families lack knowledge regarding specialized geriatric healthcare thus severely hampering access. Therefore developing methods (such as the AAI) to educate and disseminate the information is imperative.
- Develop methods to recruit and retain a geriatric workforce in rural settings such as increased compensation, loan forgiveness for education or through tax incentives
- The Administration on Aging should support a national debate that focuses on developing ways to provide transportation.

2) Workforce

- Increase Graduate Medical Education (GME) dollars should be targeted toward increasing geriatric preparation across disciplines.
- Interdisciplinary education should be incorporated as a required and integral part of the core curriculum for all healthcare disciplines
- There is considerable evidence that states if pay were increased for home care workers, there would be increased availability of this type worker. This needs

to be a public debate that focuses on how we as a country care for our older adults.

- CMS and other insurance payers should provide compensation for providing geriatric care that is competitive with other primary care specialties such as internal medicine.
- Increase emphasis of geriatric education to the existing workforce through the geriatric education centers with increased funding.
- Geriatric education should be mandatory in all healthcare related disciplines Accrediting and licensing bodies in each of the disciplines should mandate geriatric knowledge.
- Seek public/private funding to support health professional education in geriatrics.

3) Consumer Directed Care

- CMS and other payors must recognize the need and provide compensation for Geriatric Health Educational programming for seniors and community members that target health literacy skills for older adults and their families as part of a preventative care model.
- The use of plain language and communication with older adults must be incorporated into geriatric education curriculums for health professionals thus empowering older adults to become informed consumers of health services rather than recipients of healthcare.
- CMS and other insurance payers must recognize and provide adequate compensation for cost effective, alternative community based services which can be individualized to support the needs of compromised older adults wishing to residing in the community. This approach is essential for consumer directed care that will result in decreased and unnecessary institutionalization.

4) Reimbursement/Cost

- CMS should factor in the increased amount of time required for the proper care of older adults in the reimbursement formulas.
- Provide direct reimbursement for other health care and social service disciplines critical to the care of older adults. These disciplines include nutrition, social work, and pharmacy.
- Support research regarding the cost benefit of care management of the frail older adult with respect to decreasing hospitalizations, ER visits, premature nursing home placement and length of stay in acute care settings.
- Eliminate the geographic wage index between urban and rural settings.

5) Quality and outcomes

- best practices developed by CMS should be mandatory in all practices that provides care reimbursed by Medicare and Medicaid

- CMS should make if possible over the next five to ten years that all primary care practices providing care to older adults will have an electronic medical record.
- AHRQ, NIH and CMS should allocate funding to test integrated models of care delivery that target broad population groups.